CORPORATE CREATIONS®
Registered Agent • Director • Incorporation
Corporate Creations Network Inc.
801 US Highway 1 North Palm Beach, FL 33408

Publix Asset Management Company
Merriann Metz General Counsel & Secretary
Publix Super Markets Inc.
3300 Publix Corporate Parkway
Lakeland FL 33811

12/14/2021

SERVICE OF PROCESS NOTICE

The following is a courtesy summary of the enclosed document(s). **ALL information should be verified by you.**

Item: 2021-10641

Note: Any questions regarding the substance of the matter described below, including the status or how to respond, should be directed to the contact set forth in line 12 below or to the court or government agency where the matter is being heard. IMPORTANT: All changes or updates to the SOP contact individuals or their contact information must be submitted in writing to SOPcontact@corpcreations.com. Any changes will become effective upon written confirmation of Corporate Creations.

1.	**Entity Served:**	Publix Asset Management Company
2.	**Title of Action:**	Angelica Cruz-Romo, et al. vs. Publix Super Markets, Inc.; et al.
3.	**Document(s) Served:**	Summons Complaint Exhibits Plaintiff's First Set of Interrogatories and Requests for Production
4.	**Court/Agency:**	Davidson County Circuit Court
5.	**State Served:**	Tennessee
6.	**Case Number:**	21C2157
7.	**Case Type:**	Negligence/Personal Injury
8.	**Method of Service:**	Hand Delivered
9.	**Date Received:**	Monday 12/13/2021
10.	**Date to Client:**	Tuesday 12/14/2021
11.	**# Days When Answer Due:** **Answer Due Date:**	30 Wednesday 01/12/2022 CAUTION: Client is solely responsible for verifying the accuracy of the estimated Answer Due Date. To avoid missing a crucial deadline, we recommend immediately confirming in writing with opposing counsel that the date of the service in their records matches the Date Received.
12.	**Sop Sender:** **(Name, City, State, and Phone Number)**	Michael K. Parsley Goodlettsville, TN 615-749-6127
13.	**Shipped To Client By:**	Regular Mail and Email with PDF Link
14.	**Tracking Number:**	
15.	**Handled By:**	431
16.	**Notes:**	None

NOTE: This notice and the information above is provided for general informational purposes only and should not be considered a legal opinion. The client and their legal counsel are solely responsible for reviewing the service of process and verifying the accuracy of all information. At Corporate Creations, we take pride in developing systems that effectively manage risk so our clients feel comfortable with the reliability of our service. We always deliver service of process so our clients avoid the risk of a default judgment. As registered agent, our role is to receive and forward service of process. To decrease risk for our clients, it is not our role to determine the merits of whether service of process is valid and effective. It is the role of legal counsel to assess whether service of process is invalid or defective. Registered agent services are provided by Corporate Creations Network Inc.

CIRCUIT COURT SUMMONS NASHVILLE, TENNESSEE

Service ID 266475

STATE OF TENNESSEE
DAVIDSON COUNTY
20TH JUDICIAL DISTRICT

ANGELICA CRUZ-ROMO , et al.

Plaintiff

vs.

PUBLIX ASSET MANAGEMENT COMPANY
205 POWELL PLACE
C/O CORPORATE CREATIONS NET
BRENTWOOD, TN 37027

Defendant

CIVIL ACTION
DOCKET NO. 21C2157
Method of Service:
Williamson County Sheriff

Service ID 266475

To the above named Defendant:

You are summoned to appear and defend a civil action filed against you in the Circuit Court, 1 Public Square, Room 302, P.O. Box 196303, Nashville, TN 37219-6303 , and your defense must be made within thirty (30) days from the date this Summons is served upon you. You are further directed to file your defense with the Clerk of the Court and send a copy to the Plaintiff's attorney at the address listed below.

In case of your failure to defend this action by the above date, judgment by default will be rendered against you for the relief demanded in the Complaint.

ISSUED: 12/06/2021

RICHARD R. ROOKER
Circuit Court Clerk
Davidson County, Tennessee

By: _____

Deputy Clerk

ADDRESS OF PLAINTIFF'S ATTORNEY OR PLAINTIFF:

MICHAEL K. PASLEY PARSLEY
400 PROFESSIONAL PARK DRIVE
GOODLETTSVILLE, TN 37072

NOTICE TO THE DEFENDANT:

Tennessee law provides a Ten Thousand and 00/100 Dollars ($10,000.00) debtor's equity interest personal property exemption from execution or seizure to satisfy a judgment. If a judgment should be entered against you in this action and you wish to claim property as exempt, you must file a written list, under oath, of the items you wish to claim as exempt with the Clerk of the Court. The list may be filed at any time and may be changed by you thereafter as necessary; however, unless it is filed before the judgment becomes final, it will not be effective as to any execution or garnishment issued prior to the filing of the list. Certain items are automatically exempt by law and do not need to be listed; these include items of necessary wearing apparel (clothing) for yourself and your family and trunks or other receptacles necessary to contain such apparel, family portraits, the family Bible, and school books. Should any of these items be seized, you would have the right to recover them. If you do not understand your exemption right or how to exercise it, you may wish to seek the counsel of a lawyer.

To request an ADA accommodation, please contact Dart Gore at (615) 880-3309

CIRCUIT COURT SUMMONS

NASHVILLE, TENNESSEE

Service ID 266475

STATE OF TENNESSEE
DAVIDSON COUNTY
20TH JUDICIAL DISTRICT

ANGELICA CRUZ-ROMO , et al.

Plaintiff

vs.

PUBLIX ASSET MANAGEMENT COMPANY
205 POWELL PLACE
C/O CORPORATE CREATIONS NET
BRENTWOOD, TN 37027

Defendant

CIVIL ACTION
DOCKET NO. 21C2157
Method of Service:
Out of County Sheriff

Service ID 266475

RETURN ON PERSONAL SERVICE OF SUMMONS

I hereby certify and return that on the _____day of _____ _____ _____, 20___, I:

_____ served this Summons and Complaint/Petition on _____ in the following manner:

_____

_____ failed to serve this Summons within 90 days after its issuance because _____

_____

_____
Sheriff/Process Server

To request an ADA accommodation, please contact Dart Gore at (615) 880-3309

rev. 09/01/2018

IN THE CIRCUIT COURT OF DAVIDSON COUNTY, TENNESSEE

ANGELICA CRUZ-ROMO and ROGELIO GARCIA *Plaintiffs*,	)	JURY DEMAND
v.	)	Docket No. _____
PUBLIX SUPER MARKETS, INC., PUBLIX ASSET MANAGEMENT COMPANY, and PUBLIX TENNESSEE, LLC. *Defendants.*	)	BEFORE THE HONORABLE _____

COMPLAINT

COME NOW PLAINTIFFS and for their complaint against Defendants state:

1. Plaintiffs Angelica Cruz-Romo and Rogelio Garcia, a married couple, are citizens and residents of Davidson County, Tennessee.

2. Defendant Publix Super Markets, Inc. is a Florida corporation with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.

3. Defendant Publix Super Markets, Inc. may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.

4. Defendant Publix Tennessee, LLC is a Florida limited liability company with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.

5. Defendant Publix Tennessee, LLC may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.

6. Defendant Publix Asset Management company is a Florida corporation with a principal office located at 3300 Publix Corporate Parkway, Lakeland, Florida 33811.

7. Defendant Publix Asset Management Company may be served with process through its registered agent, Corporate Creations Network, Inc., 205 Powell Place, Brentwood, Williamson County, Tennessee 37027-7522.

8. Plaintiff's cause of action arises out of a January 30, 2021, incident in which Plaintiff Angelica Cruz-Romo suffered serious injuries as a result of being struck by a lifting cart and/or other machinery owned and operated by Defendants on the premises of Defendants' commercial establishment, the Publix Supermarket located at 3532 Murfreesboro Pike, Antioch, Davidson County, Tennessee 37013.

9. This Court has jurisdiction over this cause pursuant to Tenn. Code Ann. § 16-10-101.

10. Venue is proper pursuant to Tenn. Code Ann. § 20-4-104, as the events and omissions giving rise to this cause of action occurred in Davidson County.

11. At all times relevant herein, Defendants owned and operated the Publix Supermarket Mt. View marketplace located at 3532 Murfreesboro Pike, Antioch, Davidson County, Tennessee 37013 ("Publix 1235").

12. At all times relevant herein, Plaintiff Angelica Cruz-Romo was exercising reasonable care for her own safety.

13. On or about January 30, 2021, Plaintiff Angelica Cruz-Romo was shopping at Publix 1235.

14. Plaintiff Angelica Cruz-Romo was waiting for a prescription when she was struck by a lifting cart and/or other machinery owned and operated by Defendants' employees, agents, or servants.

15. The lifting cart and/or other machinery was being operated by Defendants' employees, agents, or servants, who were acting in the course and scope of their employment at the time of the incident.

16. Defendants had a duty to exercise reasonable care in the operation of the lifting cart and/or machinery.

17. Defendants failed to exercise reasonable care in the operation of the lifting cart and/or machinery, causing it to strike Plaintiff Angelica Cruz-Romo.

18. As a result of being struck by the lifting cart and/or other machinery, Plaintiff Angelica Cruz-Romo suffered serious injuries.

19. As a result of the incident, Plaintiff Rogelio Garcia has suffered the loss of consortium, companionship, society, and affection usually enjoyed in the marital relationship with his wife, Plaintiff Angelica Cruz-Romo.

20. As a direct and proximate result of one or more acts of negligence and/or recklessness of Defendants, Plaintiffs are entitled to compensation for the following damages:

a. Physical pain, both past and future;

b. Emotional suffering and grief, both past and future;

c. Health care expenses, both past and future;

d. Loss of enjoyment of life;

e. Permanent impairment and partial disability;

f. Loss of consortium;

g. Loss of earning capacity;

h. Lost wages;

i. Costs of this cause; and

j. All other general damages and other relief allowed under the laws of the State of Tennessee.

PRAYER

WHEREFORE, PLAINTIFFS PRAY:

1. For process to issue and be served upon Defendants, requiring Defendants to answer the allegations herein;
2. For a jury to be empaneled to try this cause;
3. For a judgment in favor of Angelica Cruz-Romo against Defendants for compensatory damages in an amount to be determined by the jury but not to exceed $200,000.00;
4. For a judgment in favor of Romelio Garcia against Defendants for compensatory damages in an amount to be determined by the jury but not to exceed $50,000.00;
5. For costs of this action to be taxed to Defendants; and
6. For such other, further, and general relief as this Court deems just and proper.

Respectfully submitted,

MICHAEL D. PONCE & ASSOCIATES, PLLC

BY: _____

MICHAEL K PARSLEY, BPR No. 023817
400 Professional Park Drive
Goodlettsville, Tennessee 37072
Phone: (615) 749-6127
Fax: (615) 859-7033
michaelp@poncelaw.com
Counsel for Plaintiffs

TWO RIVERS EMERG PHYS, PLLC
PO BOX 37983
PHILADELPHIA, PA 19101-7983

TAX ID# 46-3901187
131309-0002262915400-01
#BWNJFDB
#000000MMI9199489#
ANGELICA CRUZ ROMO
1712 BIRDSONG CHASE DRIVE
ANTIOCH, TN 37013

MMI

STATEMENT OF ACCOUNT (0)

Statement Date: 06/09/21

Account Number: MMI002262915400
Patient Name: ANGELICA CRUZ ROMO

Services provided at:

TRISTAR SUMMIT MEDICAL CENTER - 5655 FRIST BLVD - HERMITAGE TN 37076-2053

Date of Service	CPT Code	Description	Provider	Charges
01/30/2021	99284	EMERG INJURY EVAL & MGMT-LVL 4	DR. GREER	$1,148.00

Total Charges $1,148.00

PLAINTIFF'S EXHIBIT A

PATIENT NO: 226291540 SUMMIT MEDICAL CENTER BILLING DATE PAGE 1 00025
MED REC NO: 372921 5655 FRIST BOULEVARD 02/03/21
GUARANTOR NO:
PATIENT: HERMITAGE TN 370762053 ADMITTED DISCHARGED
GARCIA ANGELICA 01/30/21 01/30/21

PAY TO ADDRESS: SUMMIT MEDICAL CENTER
PO BOX 402551
ATLANTA
GA 303842551

BILL TO:
GARCIA ANGELICA EMERGENCY PC=08
1712 BIRDSONG CHASE DRIV ADMIT THRU DISCHARGE CLAIM
ANTIOCH TN
37013

DATE OF SERVICE	BATCH REF	DEPT	F S	NDC/CPT-4/ HCPCS	QTY	SERVICE DESCRIPTION	CHARGES
301-LAB/CHEMISTRY							
013021	30B998	0736		802140 80053	1	COMP METABOLIC PANEL	705.80
						SUBTOTAL:	705.80
305-LAB/HEMATOLOGY							
013021	30B998	0736		800270 85027	1	CBC AUTOMATED	327.18
						SUBTOTAL:	327.18
307-LAB/UROLOGY							
013021	30B998	0736		800509 81001	1	UA W MICRO AUTO	170.01
						SUBTOTAL:	170.01
352-CT SCAN/BODY							
013021	30B002	0726		325952 74177	1	CT ABD&PELVIS W/CONT	12531.53
						SUBTOTAL:	12531.53
450-EMERG ROOM							
013021	01B209	0760		319041 99284	1	LVL 4 EMER DEPT	2442.16
						SUBTOTAL:	2442.16
636-DRUGS/DETAIL CODE							
013021	30B002	0718		065909 Q9967	100	LOCM 300-399 IC 100ML	104.00
						SUBTOTAL:	104.00
						TOTAL ANCILLARY CHARGES	16280.68

PATIENT NO:	226291540	SUMMIT MEDICAL CENTER	BILLING DATE	PAGE 2	00025	
MED REC NO:	372921	5655 FRIST BOULEVARD	02/03/21			
GUARANTOR NO:						
PATIENT:		HERMITAGE	TN 370762053	ADMITTED	DISCHARGED	
GARCIA ANGELICA				01/30/21	01/30/21	

TOTAL CHARGES 16280.68

DEPARTMENTAL CHARGE SUMMARY

DEPT	DESCRIPTION	AMOUNT
0718	MATERIALS MANAGEMENT	104.00
0726	CT SCAN	12,531.53
0736	LABORATORY	1,202.99
0780	EMERGENCY ROOM	2,442.16

REVENUE CHARGE SUMMARY

REV CD	DESCRIPTION	TOTAL
0301	LAB/CHEMISTRY	705.80
0305	LAB/HEMATOLOGY	327.18
0307	LAB/UROLOGY	170.01
0352	CT SCAN/BODY	12,531.53
0450	EMERG ROOM	2,442.16
0636	DRUGS/DETAIL CODE	104.00

TOTAL CHARGES: 16,280.68

SUMMIT MEDICAL CENTER	SUMMIT MEDICAL CENTER	PAT. CNTL # 226291540	[redacted]
5655 FRIST BOULEVARD	PO BOX 402551	MED. REC. # 000000372921	0131
HERMITAGE TN 370762053	ATLANTA GA30384	FED. TAX NO. 62-1113737	STATEMENT COVERS PERIOD FROM 013021 THROUGH 013021
6158864788			

PATIENT NAME: GARCIA, ANGELICA

PATIENT ADDRESS: 1712 BIRDSONG CHASE DRIV, ANTIOCH TN 37013

BIRTHDATE	SEX	ADMISSION DATE	HR	TYPE	SRC	DHR	STAT	CONDITION CODES	ACDT STATE	
03051969	F		13	1	1		01			RED

OCCURRENCE CODE	DATE	OCCURRENCE CODE	DATE		VALUE
11	013021	A1	012068	[redacted]	00025

[redacted]

REV. CD.	DESCRIPTION	HCPCS / RATE / HIPPS CODE	SERV. DATE	SERV. UNITS	TOTAL CHARGES	NON-COVERED CHARGES
0301	COMP METABOLIC PANEL	80053	013021	1	705 80	
0305	CBC AUTOMATED	85027	013021	1	327 18	
0307	UA W MICRO AUTO	81001	013021	1	170 01	
0352	CT ABD&PELVIS W/CONT	74177	013021	1	12531 53	
0450	LVL 4 EMER DEPT	99284	013021	1	2442 16	
0636	LOCM 300399 IC 100ML	Q9967	013021	100	104 00	
0001	PAGE 001 OF 001	CREATION DATE	020321	TOTALS	16280 68	

00025 Relay 02/04/2021

E-FILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

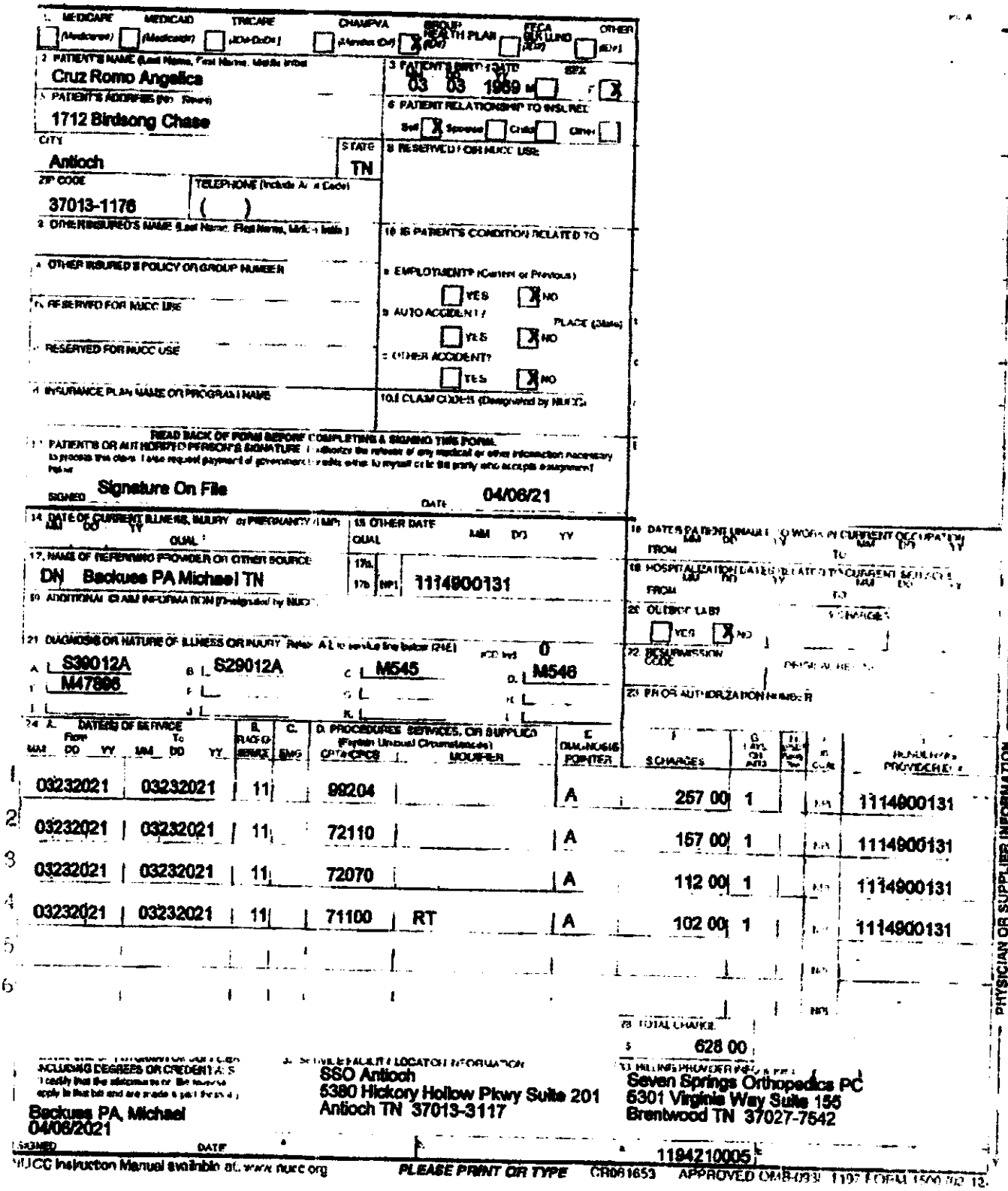
[object Object]

RADIOLOGY ALLIANCE PC
P O BOX 440166
NASHVILLE TN 37244-0166
(800)475-6112

Patient:
Acct #: 930148
GARCIA,ANGELICA
1712 BIRDSONG CHASE DRIVE
ANTIOCH,TN 37013

Srvc. Date	CPT	Proc. Description	Charge
01/30/2021	74177	CT, ABD AND PEL; W/ CONT	$311.00
01/30/2021	G9637	FINAL REPORTS WITH DOCUM	$0.00

Reproduced: Tuesday,



1. MEDICARE (Medicare#) | MEDICAID (Medicaid#) | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) [X] | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3. PATIENT'S BIRTH DATE: 03 03 1989 | SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Antioch | STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. RESERVED FOR NUCC USE:

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

c. RESERVED FOR NUCC USE:

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. CLAIM CODES (Designated by NUCC):

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File | DATE: 04/06/21

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED:

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY | QUAL:

15. OTHER DATE: MM DD YY | QUAL:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY | FROM: | TO:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a.

17b. NPI: 1114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY | FROM: | TO:

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC):

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: (Relate A-L to service line below (24E)) ICD Ind. 0

A. S39012A | B. S29012A | C. M545 | D. M546

E. M47896 | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE: | ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATES OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03232021	03232021	11		99204		A	257 00	1		NPI	1114900131
2 03232021	03232021	11		72110		A	157 00	1		NPI	1114900131
3 03232021	03232021	11		72070		A	112 00	1		NPI	1114900131
4 03232021	03232021	11		71100	RT	A	102 00	1		NPI	1114900131
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER (SSN or EIN):

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 628 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS: I certify that the statements on the reverse apply to this bill and are made a part thereof.

Backues PA, Michael
04/06/2021
SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION:

SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

33. BILLING PROVIDER INFO & PH #:

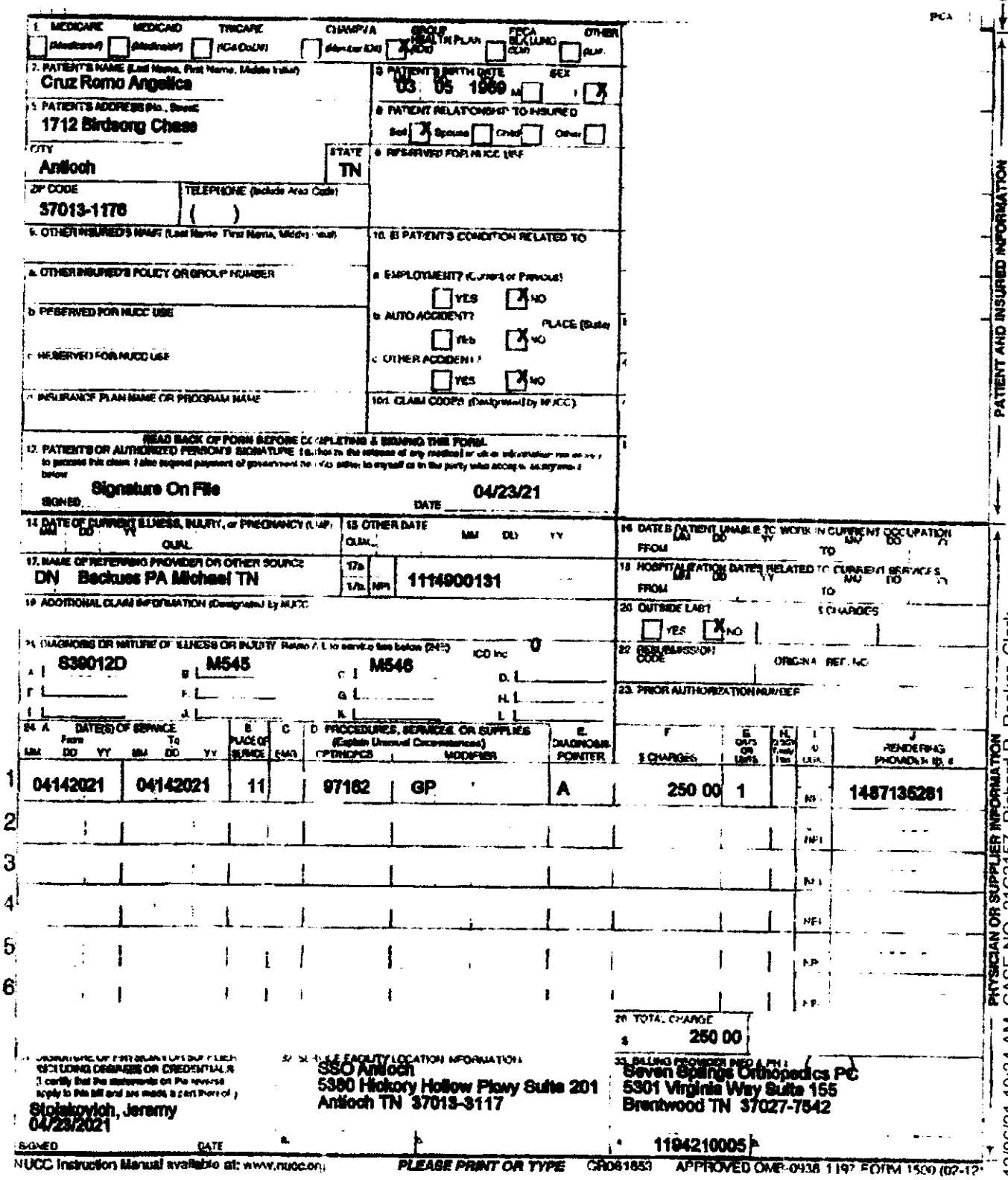
Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

1194210005

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | CR061653 | APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION | PATIENT AND INSURED INFORMATION | CARRIER

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk



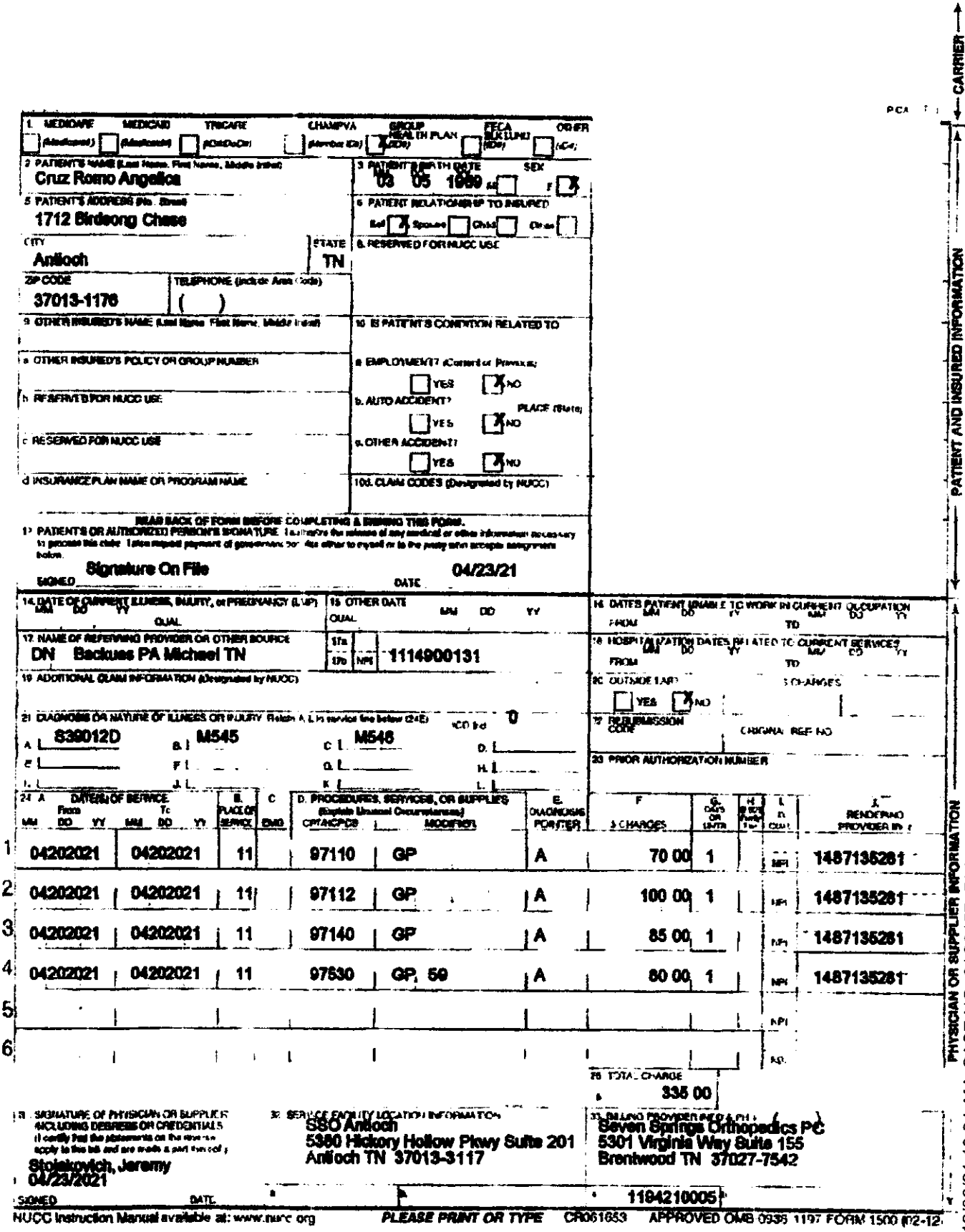
1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☒ FECA BLK LUNG ☐ OTHER ☐
2. PATIENT'S NAME: Cruz Romo Angelica
3. PATIENT'S BIRTH DATE: 03 05 1989 SEX: F ☒
5. PATIENT'S ADDRESS: 1712 Birdsong Chase
6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Antioch STATE: TN
ZIP CODE: 37013-1176 TELEPHONE: ( )
7. INSURED'S NAME
8. RESERVED FOR NUCC USE
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES ☐ NO ☒
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: Signature On File DATE: 04/23/21
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.
15. OTHER DATE QUAL.
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Beckues PA Michael TN
17a.
17b. NPI 1114900131
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. S39012D B. M545 C. M546 D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 04142021	04142021	11		97162	GP	A	250 00	1		NPI	1487136281
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER (SSN or EIN)
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back)
28. TOTAL CHARGE $ 250 00
29. AMOUNT PAID
30. BALANCE DUE
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS I certify that the statements on the reverse apply to this bill and are made a part thereof.) Stoiakovich, Jeremy 04/23/2021 SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117
33. BILLING PROVIDER INFO & PH # Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542 1194210005

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061853 APPROVED OMB-0938-1197 FORM 1500 (02-12)

PICA — CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

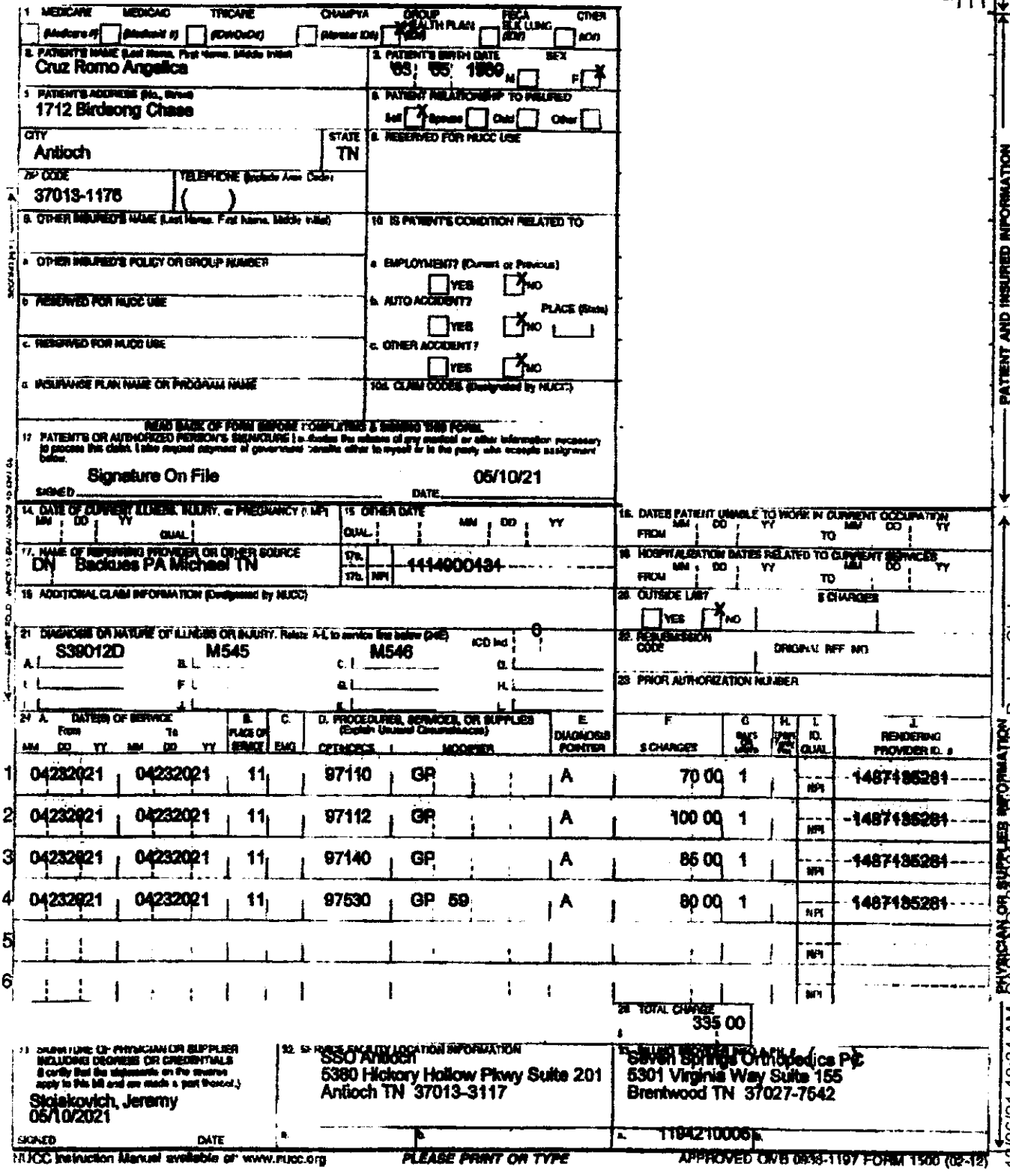


1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☒ FECA BLK LUNG ☐ OTHER ☐
2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica
3 PATIENT'S BIRTH DATE: 03 05 1999 SEX: M ☐ F ☒
5 PATIENT'S ADDRESS (No. Street): 1712 Birdsong Chase
6 PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Antioch STATE: TN
8. RESERVED FOR NUCC USE
ZIP CODE: 37013-1176 TELEPHONE (Include Area Code): ( )
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10 IS PATIENT'S CONDITION RELATED TO:
a OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒
b RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES ☐ NO ☒
d INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED: Signature On File DATE: 04/23/21
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15 OTHER DATE QUAL. MM DD YY
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Beckues PA Michael TN
17a
17b NPI 1114900131
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20 OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A S39012D B. M545 C. M546 D.
E. F. G. H.
I. J. K. L.
22 RESUBMISSION CODE ORIGINAL REF NO
23 PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 04202021	04202021	11		97110	GP	A	70 00	1		NPI	1487135261
2 04202021	04202021	11		97112	GP	A	100 00	1		NPI	1487135261
3 04202021	04202021	11		97140	GP	A	85 00	1		NPI	1487135261
4 04202021	04202021	11		97530	GP, 59	A	80 00	1		NPI	1487135261
5										NPI	
6										NPI	

25 TOTAL CHARGE $ 335 00
26 PATIENT'S ACCOUNT NO.
27 ACCEPT ASSIGNMENT? (For govt. claims, see back)
28 TOTAL CHARGE $ 335 00
29 AMOUNT PAID $
30 BALANCE DUE $
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Stoiakovich, Jeremy 04/23/2021
SIGNED DATE
32 SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117
33 BILLING PROVIDER INFO & PH #
Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542
1184210005
NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE CR061653 APPROVED OMB 0938-1197 FORM 1500 (02-12)

CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



1 MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

1a. INSURED'S I.D. NUMBER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3. PATIENT'S BIRTH DATE: 03 05 1989 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: Antioch | STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File | DATE: 05/10/21

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED | DATE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL

15. OTHER DATE QUAL | MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a. | 17b. NPI: 1114900134

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D. | E. | F. | G. | H. | I.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04232021 04232021	11		97110	GP	A	70 00	1		NPI	1487185281
2	04232021 04232021	11		97112	GP	A	100 00	1		NPI	1487185281
3	04232021 04232021	11		97140	GP	A	85 00	1		NPI	1487185281
4	04232021 04232021	11		97530	GP 59	A	80 00	1		NPI	1487185281
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 335 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy
05/10/2021

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

a. | b.

33. BILLING PROVIDER INFO & PH #

Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7642

a. 1194210006 b.

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

PICA [ ] [ ]

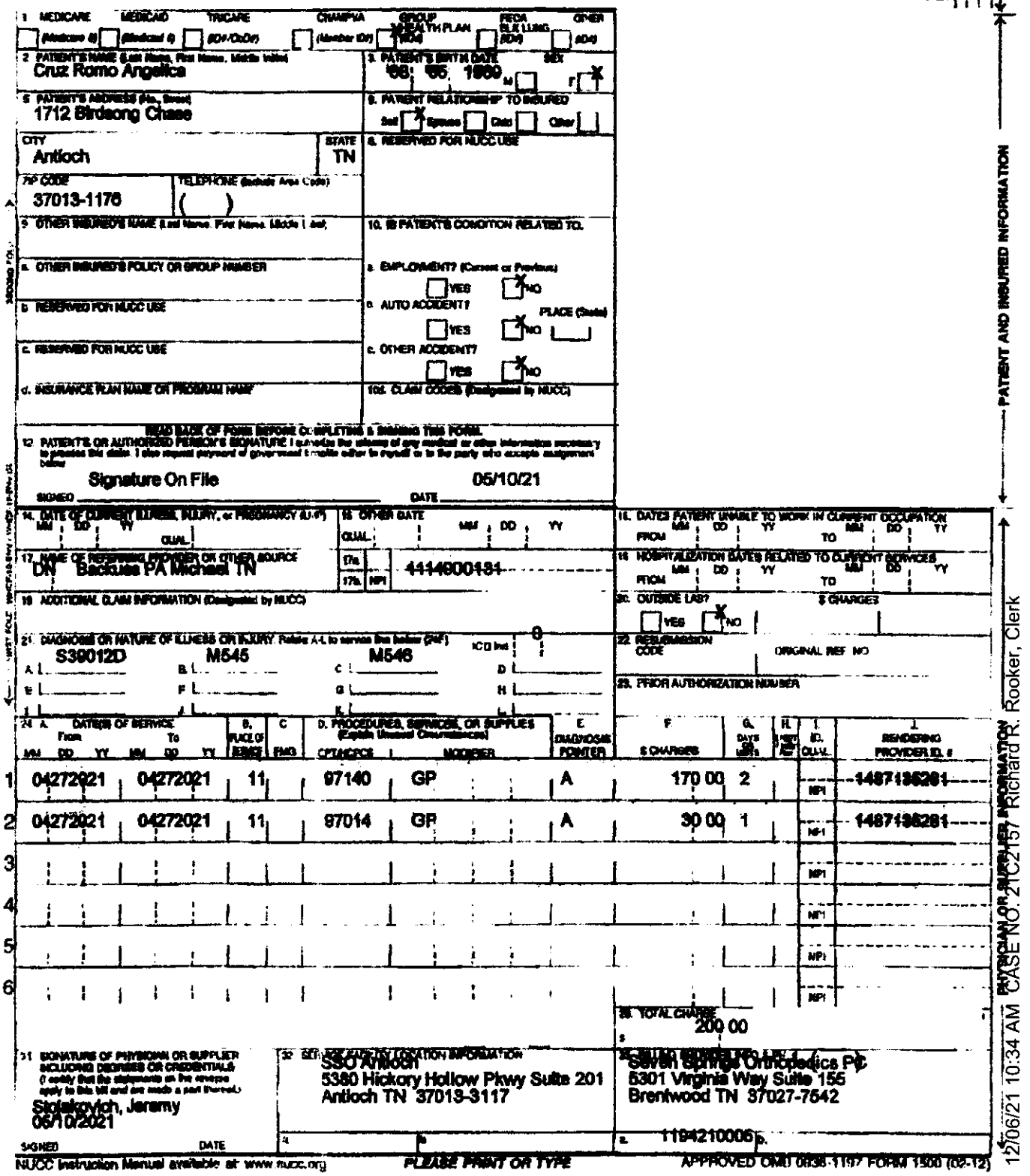
CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CASE NO. 21C2157 Richard R. Rooker, Clerk

EFILED 12/06/21 10:34 AM



1 MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

PCA | CARRIER

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3 PATIENT'S BIRTH DATE: 08 05 1999 SEX: M [ ] F [X]

5 PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: Antioch | STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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SIGNED: Signature On File | DATE: 05/10/21

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED | DATE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM | MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a | 17b NPI: 4114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM | MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D. E. F. G. H. I. J. K.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04272021	04272021	11		97140	GP	A	170 00	2		NPI 1487136281
2	04272021	04272021	11		97014	GP	A	30 00	1		NPI 1487136281
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ] | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? For govt. claims, see back YES [ ] NO [ ] | 28. TOTAL CHARGE $ 200 00 | 29. AMOUNT PAID $ | 30. Rsvd for NUCC 1

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Stoiakovich, Jeremy
06/10/2021
SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117
a. | b.

33. BILLING PROVIDER INFO & PH #
Steven Spiegel Orthopedics PC
5301 Virginia Way Suite 156
Brentwood TN 37027-7542
a. 1194210006 b.

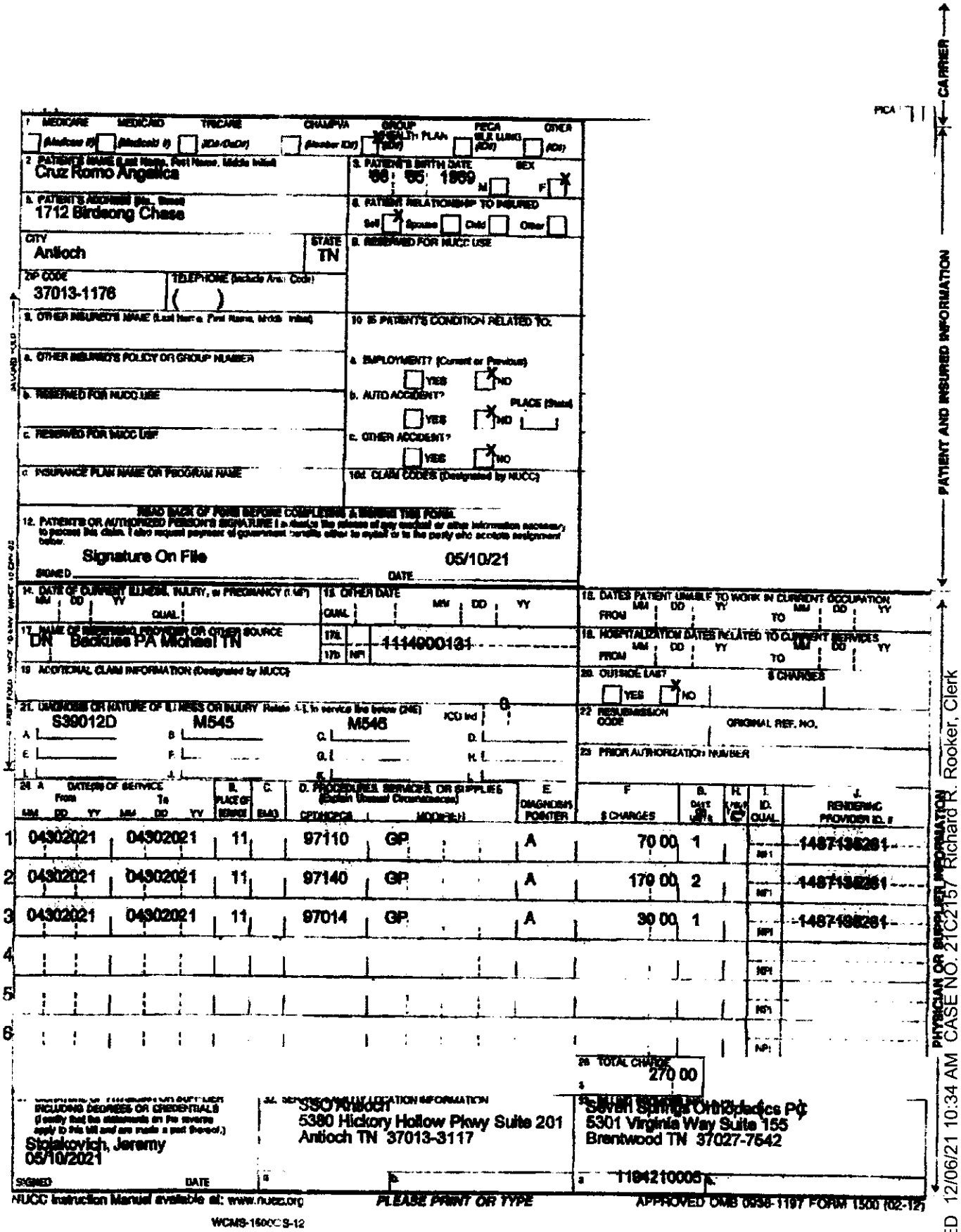
NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB-0938-1197 FORM 1500 (02-12)

WCMS-1500/CS-12

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk



1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3. PATIENT'S BIRTH DATE: 08 05 1969 | SEX: M ☐ F ☒

5. PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

CITY: Antioch | STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File | DATE: 05/10/21

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a. 1114900131 | 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. S39012D | B. M545 | C. M546 | D. | E. | F. | G. | H. | I. | J. | K.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04302021	04302021	11	97110	GP	A	70 00	1		NPI	1487196281
2	04302021	04302021	11	97140	GP	A	170 00	2		NPI	1487196281
3	04302021	04302021	11	97014	GP	A	30 00	1		NPI	1487196281
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER | SSN | EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. TOTAL CHARGE: $ 270 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy
05/10/2021

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

a. | b.

33. BILLING PROVIDER INFO & PH #

Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

a. 1194210005 | b.

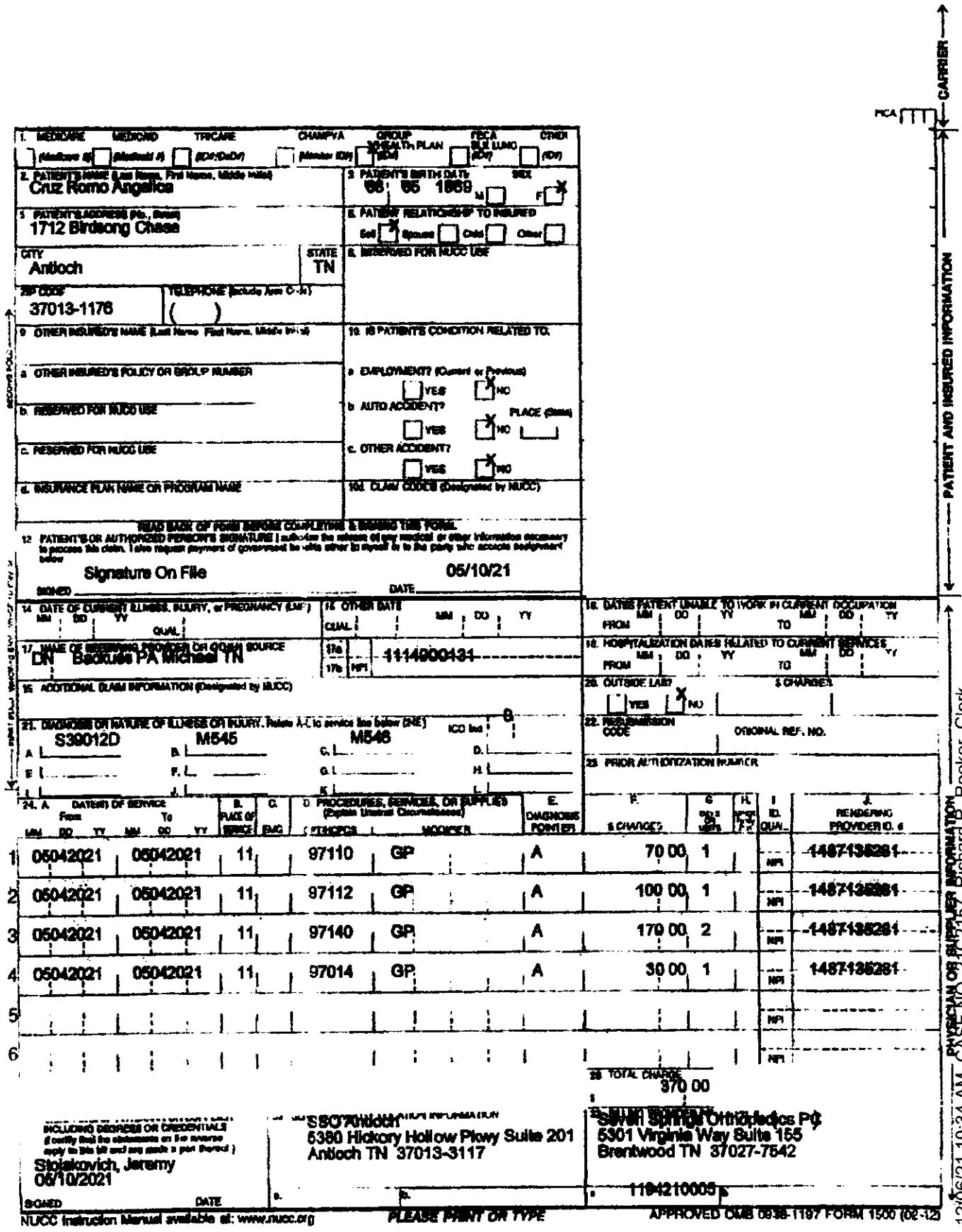
NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500 S-12

PICA | CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
2. PATIENT'S NAME: Cruz Romo Angelica
3. PATIENT'S BIRTH DATE: 06 05 1959 SEX: M ☐ F ☒
5. PATIENT'S ADDRESS: 1712 Birdsong Chase
6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Antioch STATE: TN
8. RESERVED FOR NUCC USE
ZIP CODE: 37013-1176 TELEPHONE: ( )
9. OTHER INSURED'S NAME
10. IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES ☐ NO ☒
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below
SIGNED: Signature On File DATE: 05/10/21
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL
15. OTHER DATE QUAL MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backlund PA Michael TN
17a
17b NPI 1114900131
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0
A S39012D B M545 C M546 D E F G H I J K L
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

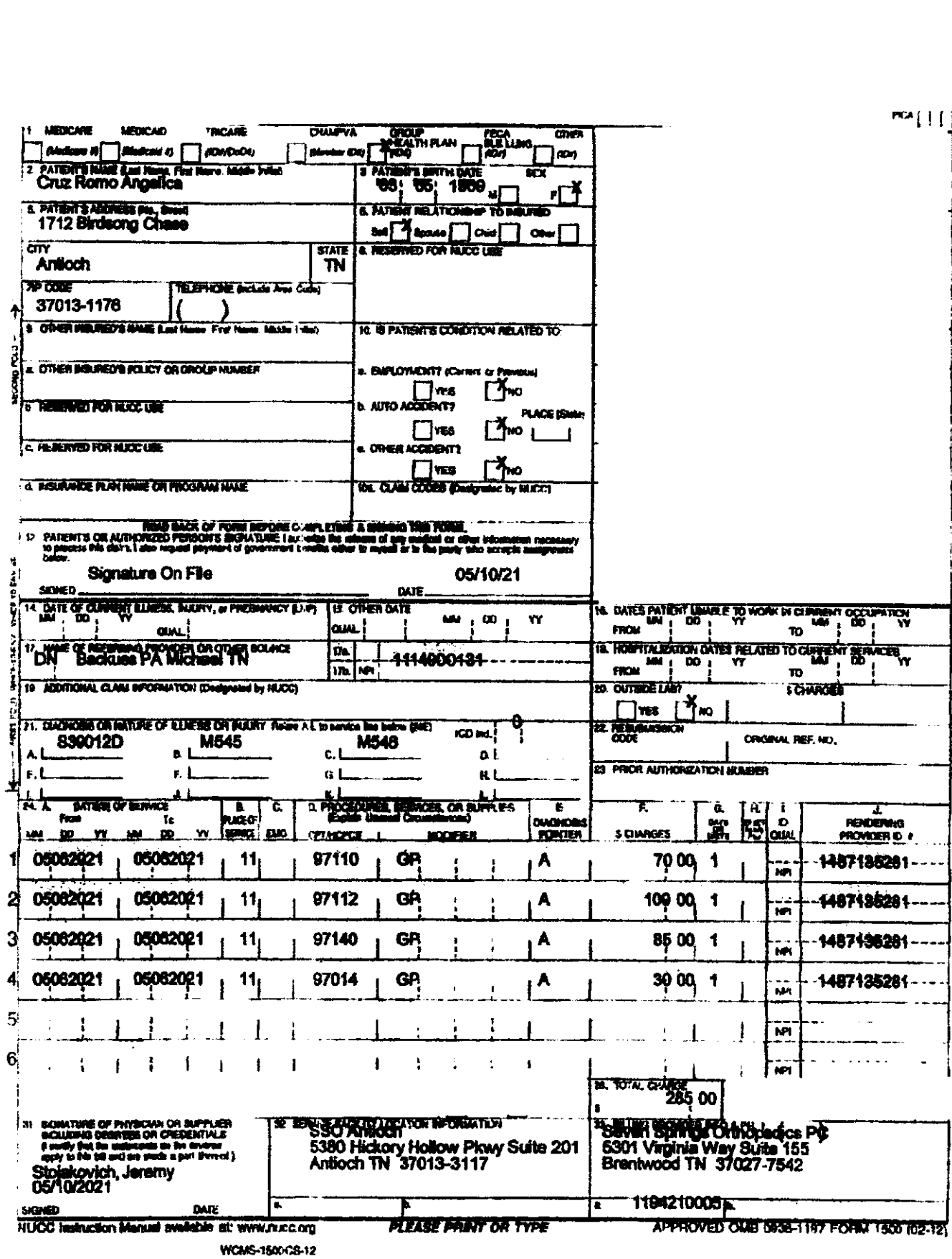
24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05042021	05042021	11		97110	GP	A	70 00	1		NPI	1487136281
2 05042021	05042021	11		97112	GP	A	100 00	1		NPI	1487136281
3 05042021	05042021	11		97140	GP	A	170 00	2		NPI	1487136281
4 05042021	05042021	11		97014	GP	A	30 00	1		NPI	1487136281
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐
28. TOTAL CHARGE $ 370 00
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Stojakovich, Jeremy 06/10/2021 SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION: SSC Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117
a. b.
33. BILLING PROVIDER INFO & PH #: Sewell Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542
a. 1194210005 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)
WCMS-1500CB-12

CARRIER
PICA
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk



1 MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐
2 PATIENT'S NAME: Cruz Romo Angelica
3 PATIENT'S BIRTH DATE: 08 05 1999 SEX: M ☐ F ☒
5 PATIENT'S ADDRESS: 1712 Birdsong Chase
6 PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐
CITY: Antioch STATE: TN
7 ZIP CODE: 37013-1176 TELEPHONE: ( )
8 RESERVED FOR NUCC USE
9 OTHER INSURED'S NAME
10 IS PATIENT'S CONDITION RELATED TO:
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒
b RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES ☐ NO ☒
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.
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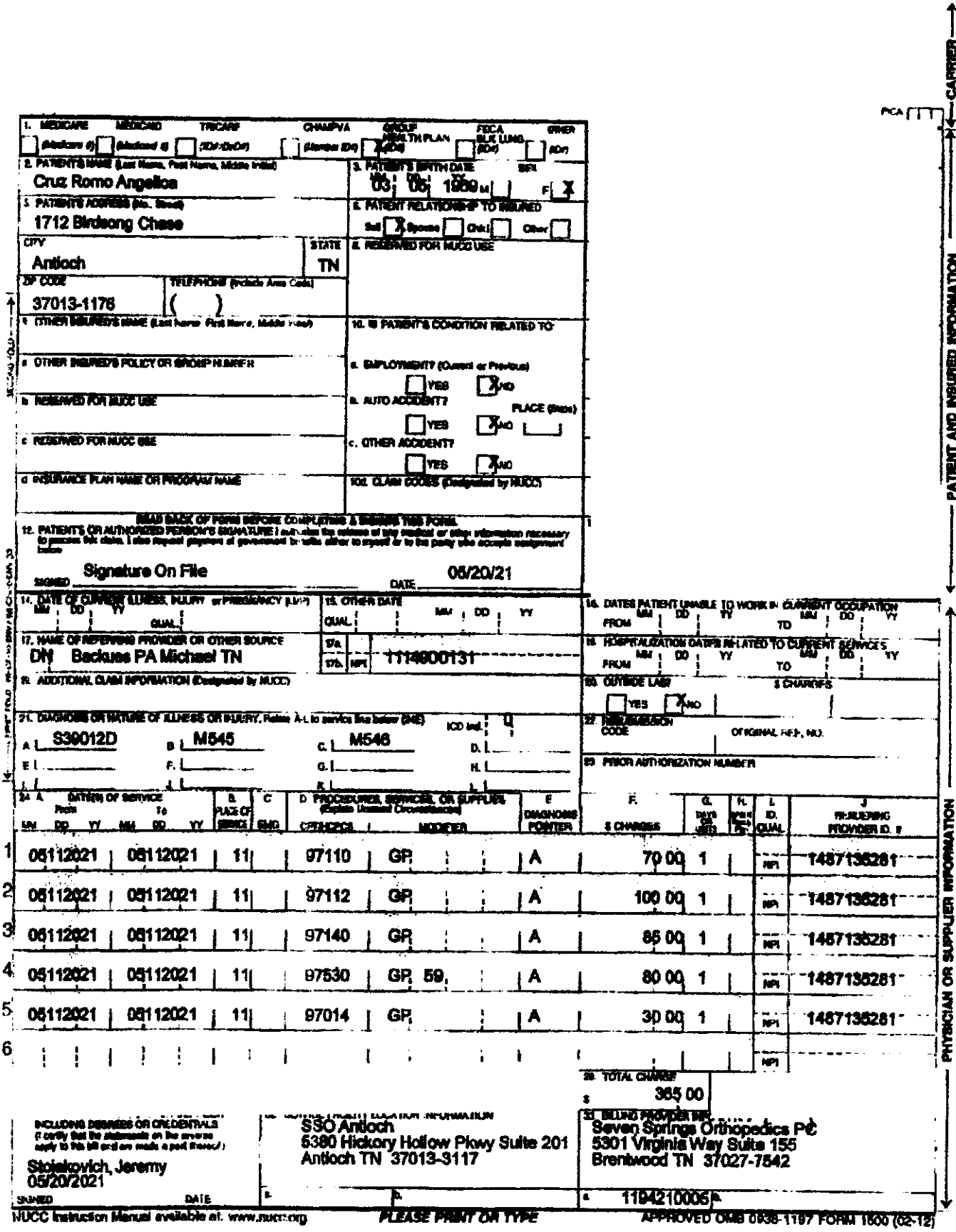
15 OTHER DATE QUAL. MM DD YY
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DR Backues PA Michael TN
17a.
17b. NPI 1114900131
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20 OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0
A. S90012D B. M545 C. M546 D. E. F. G. H. I. J. K. L.
22 RESUBMISSION CODE ORIGINAL REF. NO.
23 PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05062021	05062021	11		97110	GP	A	70 00	1		NPI	1487135281
2 05062021	05062021	11		97112	GP	A	100 00	1		NPI	1487135281
3 05062021	05062021	11		97140	GP	A	85 00	1		NPI	1487135281
4 05062021	05062021	11		97014	GP	A	30 00	1		NPI	1487135281
5										NPI	
6										NPI	

25 TOTAL CHARGE $ 285 00
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Stojakovich, Jeremy 05/10/2021 SIGNED DATE
32 SERVICE FACILITY LOCATION INFORMATION: SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117 a. b.
33 BILLING PROVIDER INFO & PH #: Steven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542 a. 1194210005 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)
WCMS-1500CS-12

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION



1. MEDICARE ☐ MEDICAID ☐ TRICARE ☐ CHAMPVA ☐ GROUP HEALTH PLAN ☐ FECA BLK LUNG ☐ OTHER ☐

2. PATIENT'S NAME: Cruz Romo Angelica

3. PATIENT'S BIRTH DATE: 03 05 1999 M ☐ F ☒

5. PATIENT'S ADDRESS: 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

CITY: Antioch

STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176

TELEPHONE: ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? YES ☐ NO ☒

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 05/20/21

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Beckues PA Michael TN

17a.

17b. NPI 1114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D. E. F. G. H. I. J. K.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 11 2021	05 11 2021	11		97110	GP	A	70 00	1		NPI	1487136281
2 05 11 2021	05 11 2021	11		97112	GP	A	100 00	1		NPI	1487136281
3 05 11 2021	05 11 2021	11		97140	GP	A	85 00	1		NPI	1487136281
4 05 11 2021	05 11 2021	11		97530	GP 59	A	80 00	1		NPI	1487136281
5 05 11 2021	05 11 2021	11		97014	GP	A	30 00	1		NPI	1487136281
6										NPI	

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back)

28. TOTAL CHARGE $ 365 00

29. AMOUNT PAID $

30. BALANCE DUE $

INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy 05/20/2021

SIGNED DATE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

SSO Antioch
6380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

32. SERVICE FACILITY LOCATION INFORMATION

a. 1194210006 b.

33. BILLING PROVIDER INFO & PH #

Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

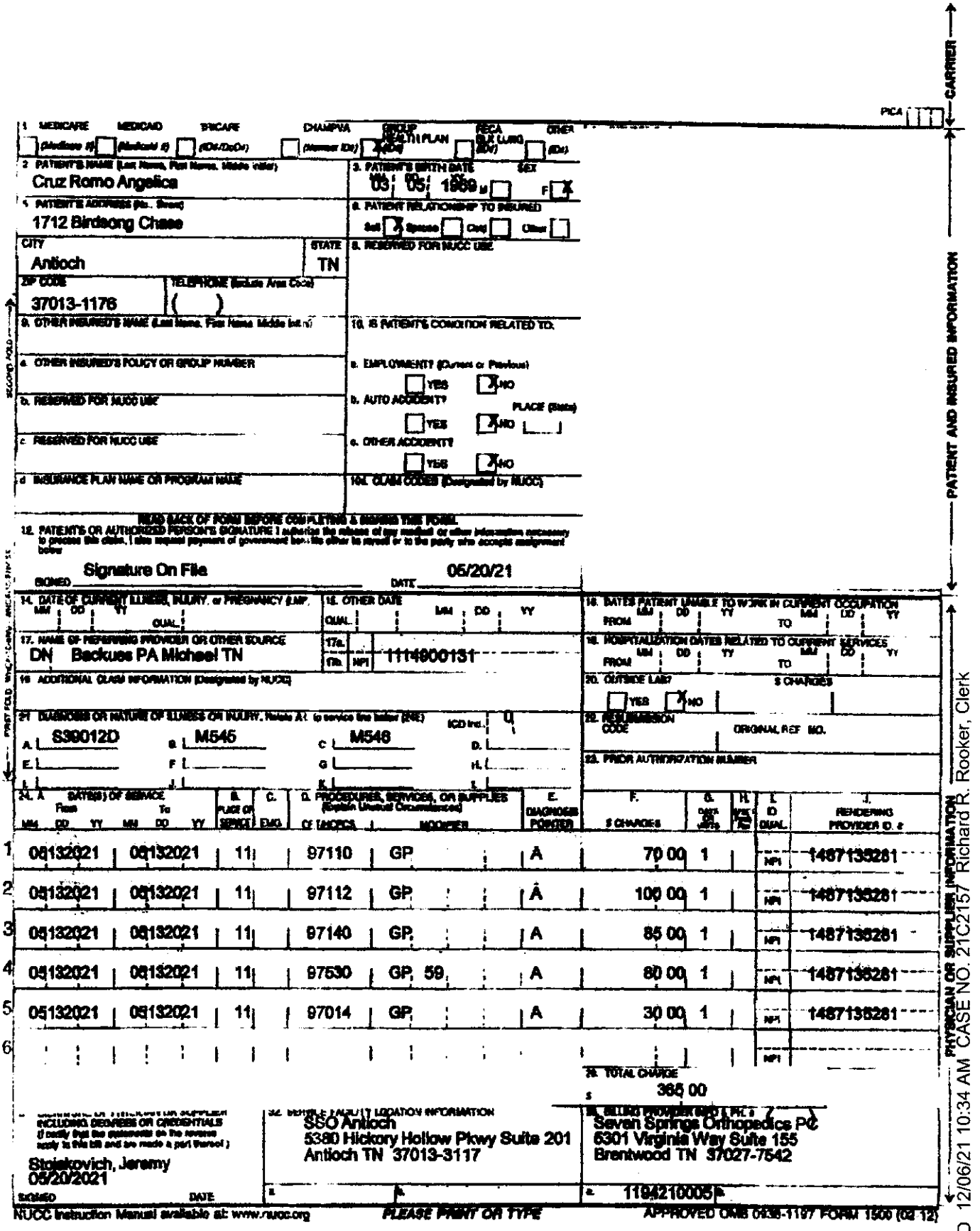
APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS 12

PICA ☐ CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



1 MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE (ID#/DoD#) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (ID#) | FECA BLK LUNG (ID#) | OTHER (ID#) | PICA

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3 PATIENT'S BIRTH DATE: 03 05 1989 | SEX: M [ ] F [X]

4 INSURED'S NAME (Last Name, First Name, Middle Initial):

5 PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: Antioch | STATE: TN

7 INSURED'S ADDRESS (No., Street):

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

8. RESERVED FOR NUCC USE

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

d INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File | DATE: 05/20/21

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY | QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Beckues PA Michael TN

17a.

17b. NPI 1114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate A-L to service line below (24E)) ICD Ind. 0

A. S39012D B. M545 C. M548 D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05132021	05132021	11		97110	GP	A	70 00	1		NPI	1487136281
2 05132021	05132021	11		97112	GP	A	100 00	1		NPI	1487136281
3 05132021	05132021	11		97140	GP	A	85 00	1		NPI	1487136281
4 05132021	05132021	11		97530	GP 59	A	80 00	1		NPI	1487136281
5 05132021	05132021	11		97014	GP	A	30 00	1		NPI	1487136281
6										NPI	

25. FEDERAL TAX I.D. NUMBER: SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ 365 00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy
05/20/2021
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

33. BILLING PROVIDER INFO & PH. #
Seven Springs Orthopedics PC
6301 Virginia Way Suite 155
Brentwood TN 37027-7542

a. 1184210005 b.

NUCC Instruction Manual available at: www.nucc.org | PLEASE PRINT OR TYPE | APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

FIRST FOLD — SECOND FOLD — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION — CARRIER

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) [X] FECA BLK LUNG (ID#) OTHER (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3. PATIENT'S BIRTH DATE / SEX: 03 05 1989 F [X]

5. PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

CITY: Antioch STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO [X] PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO [X]

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature On File DATE 05/20/21

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.

15. OTHER DATE QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN 17b. NPI 1144900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05182021	05182021	11		97110	GP	A	70 00	1		NPI	1487135281
2	05182021	05182021	11		97112	GP	A	100 00	1		NPI	1487135281
3	05182021	05182021	11		97140	GP	A	85 00	1		NPI	1487135281
4	05182021	05182021	11		97530	GP 59	A	80 00	1		NPI	1487135281
5											NPI	
6											NPI	

28. TOTAL CHARGE $ 335 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy 05/20/2021

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

a. b.

33. BILLING PROVIDER INFO & PH #
Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

a. 1194210005 b.

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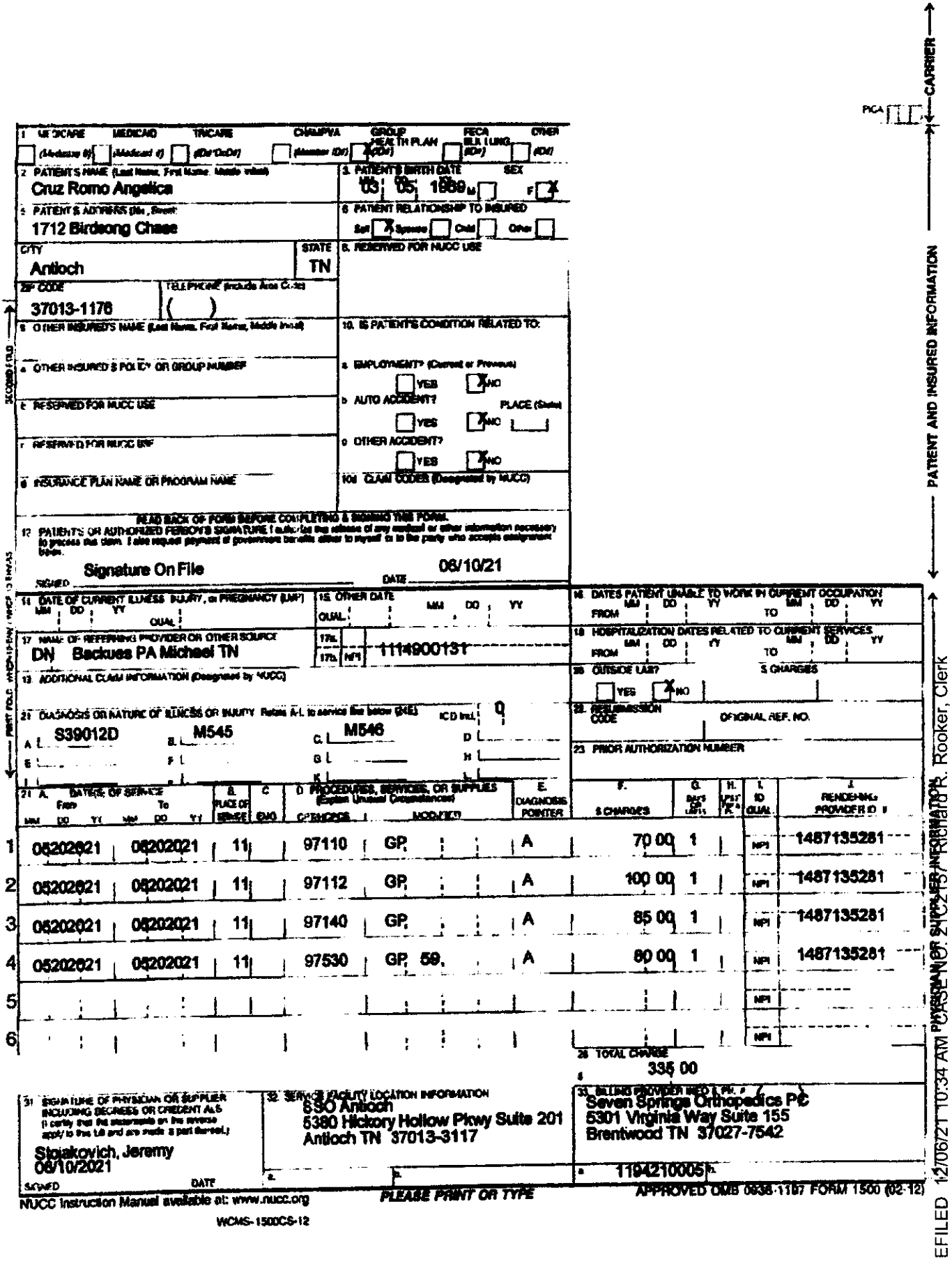
WCMB-1500CS-12

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION



PICA

1 MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3 PATIENT'S BIRTH DATE: 03 05 1999 SEX: M [ ] F [X]

5 PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: Antioch STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

b RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

c RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [ ] NO [X]

d INSURANCE PLAN NAME OR PROGRAM NAME

10d CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED: Signature On File DATE: 06/10/21

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a

17b NPI 1114900131

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A S39012D B M545 C M546 D

E F G H

I J K

22 RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05202021	05202021	11		97110	GP	A	70 00	1		NPI	1487135281
2 05202021	05202021	11		97112	GP	A	100 00	1		NPI	1487135281
3 05202021	05202021	11		97140	GP	A	85 00	1		NPI	1487135281
4 05202021	05202021	11		97530	GP 59	A	80 00	1		NPI	1487135281
5										NPI	
6										NPI	

26 TOTAL CHARGE: $ 335 00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy 06/10/2021

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION

SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

a. b.

33 BILLING PROVIDER INFO & PH. #

Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542

a 1194210005 b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

FIRST FOLD WHEN USING PAPER WINDOW ENVELOPES

SECOND FOLD

PATIENT AND INSURED INFORMATION

CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) [X] FECA BLK LUNG (ID#) OTHER (ID#)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Cruz Romo Angelica

3. PATIENT'S BIRTH DATE MM DD YY 03 06 1989 SEX M [ ] F [X]

5. PATIENT'S ADDRESS (No., Street)
1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]

CITY Antioch STATE TN

8. RESERVED FOR NUCC USE

ZIP CODE 37013-1176 TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature On File DATE 06/10/21

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN Backues PA Michael TN

17a. 17b. NPI 1114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1	05252021	05252021	11		97110	GP	A	70 00	1		NPI	1487135281
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3	05252021	05252021	11		97140	GP	A	85 00	1		NPI	1487135281
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5											NPI	
6											NPI	

28. TOTAL CHARGE $ 335 00

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Stojakovich, Jeremy
06/10/2021
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117
a. b.

33. BILLING PROVIDER INFO & PH #
Seven Springs Orthopedics PC
5301 Virginia Way Suite 155
Brentwood TN 37027-7542
a. 1194210005 b.

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WCMS-1500CS-12

CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

EFILED 12/09/21 10:34 AM CASE NO. Rooker, Clerk

PICA

1 MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3 PATIENT'S BIRTH DATE: 03 05 1969 SEX: M ☐ F ☒

5 PATIENT'S ADDRESS (No. Street): 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self ☒ Spouse ☐ Child ☐ Other ☐

CITY: Antioch

STATE: TN

8 RESERVED FOR NUCC USE

ZIP CODE: 37013-1176

TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☒

b RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

c RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☒

d INSURANCE PLAN NAME OR PROGRAM NAME

10d CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 06/10/21

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14 DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL

15 OTHER DATE MM DD YY QUAL

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a

17b NPI 1114900131

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? YES ☐ NO ☒ $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. S39012D B. M545 C. M546 D.

E. F. G. H.

I. J. K. L.

22 RESUBMISSION CODE ORIGINAL REF. NO.

23 PRIOR AUTHORIZATION NUMBER: 48103

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID. QUAL.	J RENDERING PROVIDER ID. #
1 05272021	05272021	11		97110	GP	A	70 00	1		NPI	1487135281
2 05272021	05272021	11		97112	GP	A	100 00	1		NPI	1487135281
3 05272021	05272021	11		97140	GP	A	85 00	1		NPI	1487135281
4 05272021	05272021	11		97530	GP 59	A	80 00	1		NPI	1487135281
5										NPI	
6										NPI	

25 FEDERAL TAX I.D. NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO.

27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☒

28 TOTAL CHARGE $ 335 00

29 AMOUNT PAID $

30 RESERVED FOR NUCC USE

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy
06/10/2021
SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

33 BILLING PROVIDER INFO & PH #
Seven Springs Orthopedics PC
6301 Virginia Way Suite 155
Brentwood TN 37027-7542

a 1194210005

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

PATIENT AND INSURED INFORMATION — CARRIER

EFILED 12/06/21 10:34 AM CIRCUIT COURT 3 JOHNSON, Rooker, Clerk

PICA

1 MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

2 PATIENT'S NAME: Cruz Roma Angelica

3 PATIENT'S BIRTH DATE: 03 05 1999 SEX: F X

5 PATIENT'S ADDRESS: 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self X Spouse Child Other

CITY: Antioch STATE: TN

8 RESERVED FOR NUCC USE

ZIP CODE: 37013-1178 TELEPHONE: ( )

9 OTHER INSURED'S NAME

10 IS PATIENT'S CONDITION RELATED TO:

a OTHER INSURED'S POLICY OR GROUP NUMBER

a EMPLOYMENT? (Current or Previous) YES NO X

b RESERVED FOR NUCC USE

b AUTO ACCIDENT? YES NO X PLACE (State)

c RESERVED FOR NUCC USE

c OTHER ACCIDENT? YES NO X

d INSURANCE PLAN NAME OR PROGRAM NAME

10d CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 06/10/21

14 DATE OF CURRENT ILLNESS, INJURY or PREGNANCY (LMP) MM DD YY QUAL

15 OTHER DATE QUAL MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a

17b NPI 1114900131

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? YES NO X $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind. 0

A. S39012D B. M545 C. M546 D. E. F. G. H. I. J.

22 RESUBMISSION CODE ORIGINAL REF NO

23 PRIOR AUTHORIZATION NUMBER: 48103

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06012021	06012021	11		97110	GP	A	70 00	1		NPI	1487135281
2 06012021	06012021	11		97112	GP	A	100 00	1		NPI	1487135281
3 06012021	06012021	11		97530	GP	A	160 00	2		NPI	1487135281
4										NPI	
5										NPI	
6										NPI	

28 TOTAL CHARGE: $ 330 00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy 06/10/2021

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION: SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117

a. b.

33 BILLING PROVIDER INFO & PH #: ( ) Seven Springs Orthopedics PC 6301 Virginia Way Suite 155 Brentwood TN 37027-7542

a. 1194210005 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS-1500CS-12

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EFILED 12/06/21 10:34 AM Rooker, Clerk

CARRIER

PICA

1 MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Cruz Romo Angelica

3 PATIENT'S BIRTH DATE: 03 05 1980 SEX: F [X]

5 PATIENT'S ADDRESS (No., Street): 1712 Birdsong Chase

6 PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

CITY: Antioch STATE: TN

8 RESERVED FOR NUCC USE

ZIP CODE: 37013-1178 TELEPHONE (Include Area Code): ( )

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO:

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? [ ] YES [X] NO

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature On File DATE: 06/10/21

PATIENT AND INSURED INFORMATION

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15 OTHER DATE QUAL. MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a

17b NPI: 1114800131

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20 OUTSIDE LAB? [ ] YES [X] NO $ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. S39012D B. M545 C. M546 D.

E. F. G. H.

I. J. K. L.

22 RESUBMISSION CODE ORIGINAL REF. NO

23 PRIOR AUTHORIZATION NUMBER: 48103

	24 A. DATE(S) OF SERVICE From	To	B. PLACE OF SERVICE	C. EMG	D. CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	06032021	06032021	11		97110	GP	A	70 00	1		NPI	1487135281
2	06032021	06032021	11		97112	GP	A	100 00	1		NPI	1487135281
3	06032021	06032021	11		97530	GP	A	160 00	2		NPI	1487135281
4											NPI	
5											NPI	
6											NPI	

PHYSICIAN OR SUPPLIER INFORMATION

28 TOTAL CHARGE: $ 330 00

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Stojakovich, Jeremy
06/10/2021

SIGNED DATE

32 SERVICE FACILITY LOCATION INFORMATION
SSO Antioch
5380 Hickory Hollow Pkwy Suite 201
Antioch TN 37013-3117

a. b.

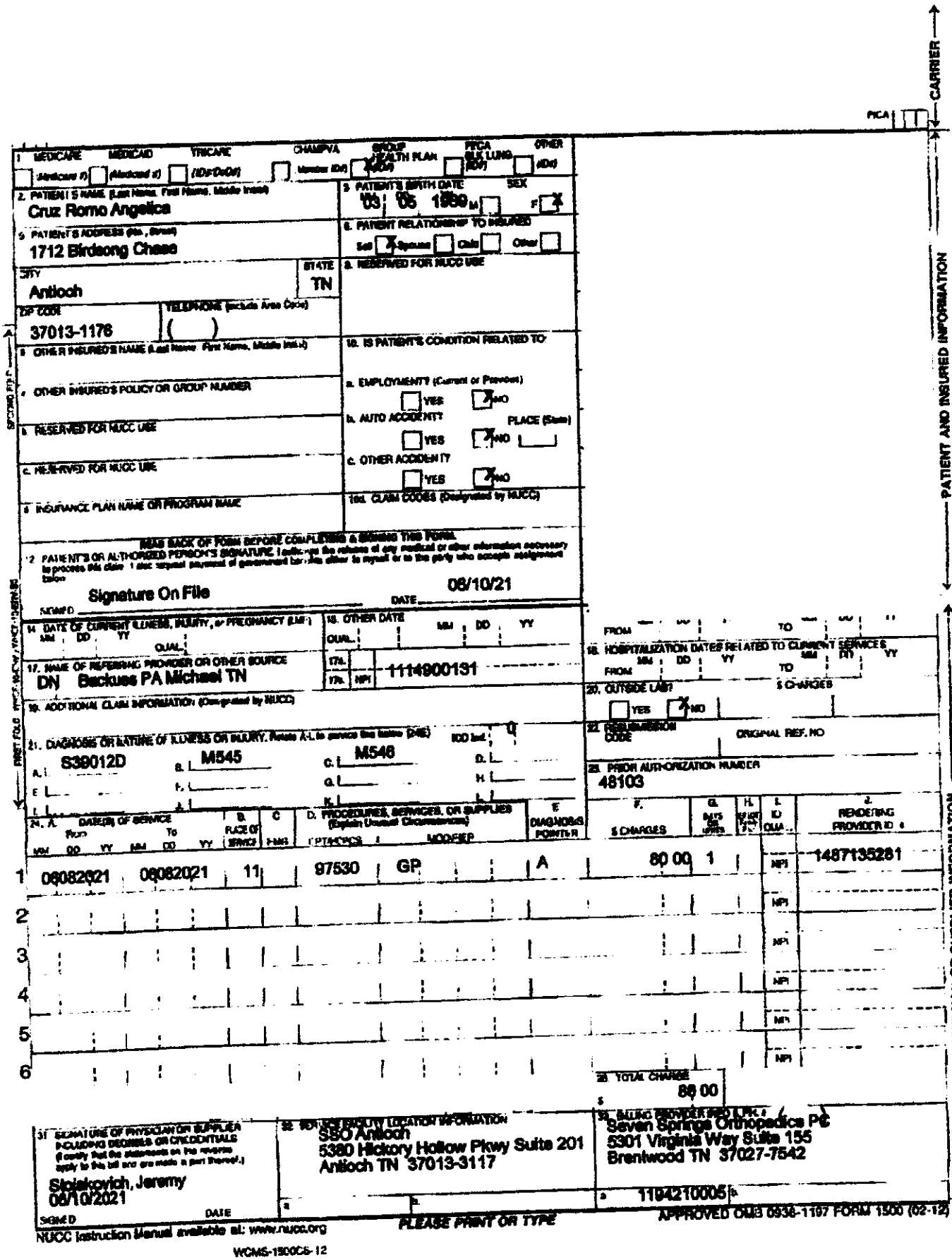
33 BILLING PROVIDER INFO & PH # ( )
Seven Springs Orthopedics PC
8301 Virginia Way Suite 155
Brentwood TN 37027-7542

a. 1194210005 b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB 0938-1197 FORM 1500 (02-12)

WCMS 1500CS-12

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk



PICA

1 MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

2. PATIENT'S NAME: Cruz Romo Angelica

3. PATIENT'S BIRTH DATE: 05 05 1999 | SEX: M | F X

5. PATIENT'S ADDRESS: 1712 Birdsong Chase

6. PATIENT RELATIONSHIP TO INSURED: Self X | Spouse | Child | Other

CITY: Antioch | STATE: TN

8. RESERVED FOR NUCC USE

ZIP CODE: 37013-1176 | TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (Current or Previous): YES | NO X

a. OTHER INSURED'S POLICY OR GROUP NUMBER

b. AUTO ACCIDENT? YES | NO X | PLACE (State)

b. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES | NO X

c. RESERVED FOR NUCC USE

10d. CLAIM CODES (Designated by NUCC)

d. INSURANCE PLAN NAME OR PROGRAM NAME

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: Signature On File | DATE: 08/10/21

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY | QUAL.

15. OTHER DATE: MM DD YY | QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION: MM DD YY | FROM | TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN Backues PA Michael TN

17a. | 17b. NPI: 1114900131

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES: MM DD YY | FROM | TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES | NO X | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E): ICD Ind. 0

A. S39012D | B. M545 | C. M546 | D. | E. | F. | G. | H. | I. | J. | K. | L.

22. RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 48103

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 06082021	06082021	11		97530	GP	A	80 00	1		NPI	1487135281
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? For govt. claims, see back. YES X | NO

28. TOTAL CHARGE: $ 80 00

29. AMOUNT PAID

30. BALANCE DUE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): Stojakovich, Jeremy 08/10/2021 | SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION: SSO Antioch 5380 Hickory Hollow Pkwy Suite 201 Antioch TN 37013-3117

33. BILLING PROVIDER INFO & PH #: Seven Springs Orthopedics PC 5301 Virginia Way Suite 155 Brentwood TN 37027-7542 | a. 1194210005

PLEASE PRINT OR TYPE

APPROVED OMB 0938-1197 FORM 1500 (02-12)

NUCC Instruction Manual available at: www.nucc.org

WCMS-1500C6-12

PATIENT AND INSURED INFORMATION — CARRIER

PLEASE DO NOT STAPLE IN THIS AREA

FIRST FOLD

EFILED 12/06/21 10:34 AM CASE NO. 21C2157 Richard R. Rooker, Clerk

IN THE CIRCUIT COURT FOR DAVIDSON COUNTY, TENNESSEE AT NASHVILLE

ANGELICA CRUZ-ROMO and ROGELIO GARCIA	)	
Plaintiffs,	)	
v.	)	**Docket No:**_____
PUBLIX SUPER MARKETS INC a/d/b/a PUBLIX ASSET MANAGEMENT COMPANY, and PUBLIX TENNESSEE LLC.	)	
Defendant.	)	

PLAINTIFF'S FIRST SET OF INTERROGATORIES AND REQUESTS FOR PRODUCTION TO THE DEFENDANT PUBLIX ASSET MANAGEMNT COMPANY

I hereby serve upon the Defendant, Publix Asset Management Company(Hereinafter "Publix AMC") the following written Interrogatories and Request for Production of Documents under the provisions of Rule 33 and 34 of the Tennessee Rules of Civil Procedure.

You are required to answer these interrogatories separately and fully in writing under oath and to serve a copy of your answers on the undersigned attorney within thirty days (30) days after service hereof.

These interrogatories shall be continuing in nature until the date of trial, and you are required to serve supplemental answers as additional information may become available to you as required by Rule 26.05 of the Tennessee Rules of Civil Procedure.

DEFINITIONS AND INSTRUCTIONS

As used in these Interrogatories and Request for Production of Documents served herewith, the following definitions and instructions shall apply:

(1) As used herein, the terms "you," "your," or "yourself" refer to the defendant, and each agent, representative, attorney, or other person acting or purporting to act for said defendant.

(2) As used herein, the term "person" means any natural individual in any capacity whatsoever or any entity or organization, including divisions, departments, and other units therein, and shall include, but not be limited to, a public or private corporation, partnership, joint venture, voluntary or unincorporated associated organization, proprietorship, trust, estate, governmental agency, commission, bureau, or department.

(3) As used herein, the term "identification," "identify," or "identity" when used in reference to (a) a natural individual, requires you to state his or her full name and residential and business address, and his or her present or last known residence and business telephone numbers; (b) a corporation, requires you to state its full corporate name and any names under which it does business, its state of incorporation, the address of its principal place of business, and the name and address of its registered agent for service of process within the State of Tennessee; or (c) a business, requires you to state the full name under which the business is conducted, its business address, the types of businesses in which it is engaged, and the identity of the person, or persons, who own, operate, and control the business.

(4) As used herein, the term "communication" means any oral or written utterance, notation, or statement of any nature whatsoever, by and to whomsoever made, including, but not limited to, correspondence, conversations, dialogues, discussions, interviews, consultations, agreements, and other understandings between or among two or more persons, by any means or made of conveying information, including but not limited to telephone, television, or telegraph.

(5) As used herein, the term "document" means any medium upon which information can be recorded or retrieved, and includes, without limitation, the original and each copy, regardless of origin and location, of any book, pamphlet, periodical,

letter, memorandum, invoice, bill, order form, receipt, financial statement, accounting entry, diary, calendar, telex, fax, telegram, cable, report, record, contract, agreement, study, handwritten note, draft, working paper, chart, paper, print, laboratory record, drawing, sketch, graph, index, list, tape, photograph, microfilm, data sheet, or any other written, recorded, transcribed, punched, taped, filmed, or graphic matter, however produced or reproduced, which is in your possession, custody, or control, or which was, but is no longer, in your possession, custody, or control.

(6) As used herein, the word "or" appearing in an interrogatory should not be read so as to eliminate any part of the interrogatory, but, whenever applicable, it should have the same meaning as the word "and".

(7) With regard to the terms defined herein, all terms used in the singular shall include the plural, and all terms used in the plural shall include the singular.

(8) If any privilege is claimed with respect to any document or communication, identify the document or communication and state the privilege claimed and the basis therefore.

INTERROGATORIES

1. For the person or persons answering these Interrogatories, please state your full name, age and date of birth, current address and any prior addresses at which you have lived during the past ten years. For each prior address, state the duration you lived there and why you moved. If more than one person participated in answering these Interrogatories, please state which Interrogatories each person answered.

RESPONSE:

2. For each person or persons answering these Interrogatories, please state your position of employment and your relationship to the Defendant.

RESPONSE:

3. Identify each person with whom you consulted, upon whom you relied, or who otherwise constituted a source of information for you in connection with the preparation of your answers to these Interrogatories, listing with respect to each such person the number(s) of the interrogatories to which such person was consulted, was relied upon, or otherwise constituted a source of information.

RESPONSE:

4. State when accident or injuries which are the subject of this Complaint first came to the attention of Defendant Publix AMC or any representatives, of Publix AMC, by whom it was reported, and to whom it was reported. Please state whether any incident report, report of injury, insurance claim report, or accident report(s) was filled out, and provide a copy of said report(s).

RESPONSE:

5. State whether or not any statement, interview, or report has been secured from the Plaintiff, and or any agent, employee, and/ as servant of Publix AMC; in

connection with this matter, by the Defendant and/ or any agent of the Defendant, including insurance companies. If so, please identify the date, place, and time the statement, interview, or report was taken; the name and address of the persons giving the statement, report or interview; the name of the persons(s) taking the report, statement and/ or interview along with the interviewers address; whether the statement was oral, written, taped, recorded, or transcribed; whether the statement, report and/ or interview was signed; and upon whose behalf the statement, interview, or report was taken or made. Please attach a copy of any recorded or written statement taken from the Plaintiff as an additional Request for Production of Document to Defendant Publix AMC. If no recorded or written statement was kept, please provide a detailed description of all information provided to you by and/ or any agent(s), employee(s) and or servant(s) by the Plaintiff and/ or connected in any way to the event causing injury to the Plaintiff, Angelica Cruz-Romo, on January 30, 2021.

RESPONSE:

6. Identify by name, address, telephone number, and relationship to any party in this lawsuit all persons believed by you to have knowledge of any discoverable evidence or information relating to either the alleged accident itself or to either the Plaintiff's or your claims for damages in this lawsuit. As part of your response, for each witness so identified briefly describe what discoverable evidence or information said witness is believed to know.

RESPONSE:

7. Identify all persons who the Defendant believes to be in possession of, or to have knowledge of, any map, picture, photograph, drawing, or other document relevant to any issue or fact concerning the incident, including the Plaintiff's injuries or any claim that the Plaintiff or some other entity was at fault for said injuries. In identifying said persons, specify name, address, telephone number, and relationship to any party.

RESPONSE:

8. Describe in detail every other accident or injury which has occurred on the common areas of the premises of the Defendant, during any time when said premises have been under the possession or control of the Defendant within the last ten years. Include the date, time, the nature of any alleged injuries, the alleged cause of said injuries, whether any claim or Complaint was filed or reported against Publix AMC, and if so, the disposition of said claim or Complaint.

RESPONSE:

9. Please state the names and addresses of every person known by Defendant Publix AMC, Defendant's representatives, agents, employee(s) and/ or Servants or Defendants attorneys to have witnessed the accident which is the subject of this Complaint, or who were present at the scene within sixty minutes before or after the accident. Designate the witnesses name along with their respective address who which of

such people claim to have witnessed the accident and please provide a synopsis and/ or summary of any statement, interview, and/ or report given or taken from any of these witnesses to the accident. As an additional request for Request for Production of Document to Defendant Publix AMC, please attach a copy of any recorded and/ or written statement taken from any and all witnesses to this accident which is the subject of the pending complain in this matter.

RESPONSE

10. List each of the following:

(a) The names and addresses of those persons who have given to you, your attorney, or any person, firm or corporation acting on your behalf, any statements, accident reports, interview, voice recordings, video recordings, tape recording, digital recordings, medical proof of claim forms, reports, or memoranda in any way concerning the incident described in the complaint which is pending in this matter.

(b) The name, telephone number, and address of the person, firm or corporation who now has possession of same.

RESPONSE:

11. For each person whom you expect to call as an expert witness at trial, whether the witness is a retained expert or non-retained expert, please state the following:

(a) The expert's full name, business address and telephone number;

(b) The expert's occupation;

(c) The subject matter on which the expert is expected to testify and the expert's hourly deposition fee;

(d) The substance of the facts and opinions to which the expert is expected to testify, including a summary of the grounds for each opinion; and

(e) The expert's qualifications to give an opinion (if such information is available on the expert's curriculum vitae, you may attach a copy thereof in lieu of answering this interrogatory subpart).

RESPONSE:

12. List the names, addresses, phone numbers, training of any persons, and resume and/ or curriculum vitae trained in analyzing, inspecting, investigating, observing, or making calculations based upon accident sites or related factors who have inspected, observed, or otherwise been in contact with the premises upon which the accident which is the subject of this Complaint occurred. Please also give the dates on which such persons observed and/ or review the accident site premises, what physical evidence was observed, what measurements were made, what opinions were formed, and

what tests were performed. In the event that a report, memorandum, and/ or any document has been created as result of such observation and/ or review, as an additional Request for Production of Document to Defendant Publix AMC, please attach a copy of said memorandum, report and/ or other document.

RESPONSE:

13. With regard to the incident, injuries or accident alleged in the Complaint, state in detail, and in your own words, your understanding of how the Plaintiff's accident and injuries occurred. Your response must include the following:

(a) Where on the premises the Plaintiff was at the time of the accident;

(b) What caused the accident to occur;

(c) Who you believe to be the at fault party;

(d) Who was present when Plaintiff was injured;

(e) Who was notified of the Plaintiff's injury;

(f) What kind of injuries Plaintiff suffered as a result of the accident, and whether Plaintiff received medical treatment for said injuries.

RESPONSE:

14. Describe in detail any conversation or discussion Defendant, Publix AMC or any agent, employee and/ or servant of Defendant, Publix AMC may have had with the Plaintiff, witnesses, or other persons having any information whatsoever regarding the incident which is the subject of this Complaint or the Plaintiff's injuries. Your

response must include the names of all parties to the conversation, if known, as well as a recitation of what was said, and the date upon which the conversation took place.

RESPONSE:

15. Have you, or any person acting on your behalf, obtained any letter, note, correspondence, computer report, official record, or other document or record relating to the medical condition of the Plaintiff or any prior accidents or injuries which may have involved the Plaintiff? If so, identify such document or record.

RESPONSE:

16. Have you or anyone working on your behalf, or on behalf of any representative of yours, made any attempt to survey, observe, photograph, and/or record, by any means, the Plaintiff to this action? If so, describe the result of the attempts, the dates of these attempts, and the identity of all individuals making such attempts. Please provide complete copies of all documents, exhibits, photographs, movies, videotapes, maps, recordings, charts, drawings, diagrams, and/or computer-generated renderings, that

depict the Plaintiff, made by the individuals identified in response to this Interrogatory. Please note that this Interrogatory is continuing in nature and must be supplemented promptly if any attempt is made before trial to survey, observe, photograph, and/or record the Plaintiff by any means.

RESPONSE:

17. Please state the name and address of any potential party to this lawsuit, not already named as a party hereto.

RESPONSE:

18. Is it your contention that any negligence or fault on the part of the Plaintiff caused or contributed to the accident or injuries which are the subject of this Complaint? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

19. Is it your contention that any negligence or fault on the part of any person or entity not already a party to this action caused or contributed to the accident or injuries which are the subject of this Complaint? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

20. Is it your contention that Plaintiff's accident or injuries were related to or caused by a hazard on Defendant Publix AMC premises and/ or on the premises of any other Defendant or person not named as a Defendant in this lawsuit. If so, please state the premises owner and/ or person or entity in control of the premises where this accident occurred which is the subject of this complaint. In addition, do you contend that the hazard causing injury to the Plaintiff was open and obvious? which was open or obvious? If so, identify and describe in detail every fact which supports your contention, and state how long the open and obvious hazard or condition had existed on Defendant's premises. If your reply is that Defendant does not know how long the open and obvious hazard existed on the premises, explain in detail why Defendant does not know how long the hazard existed on the premises.

RESPONSE:

21. Is it your contention that Plaintiff Angelica Cruz-Romo's injuries and/or medical treatment is not causally related to this incident on the Defendant's premises? If so, identify and describe in detail every fact or belief which supports your contention.

RESPONSE:

22. Please provide the name, home address, telephone number, and current employer (if known) of all persons working in the capacity of a security guard on the Defendant's premises at the time of the incident alleged in the Complaint.

RESPONSE:

23. Please provide any tape, video, audio, and/ or digital recording that could in any way depict the event(s) given rise to the subject of the complaint in this matter as and additional Request for Production of Documents.

OATH

STATE OF TENNESSEE
COUNTY OF _____

_____, being first duly sworn, hereby makes oath and avers that he/she attests the foregoing responses to the Interrogatories and Request for Production of Documents on behalf of Publix Asset Management Company in his/her capacity as _____, participated in the preparation of same, and that all of the statements made contained therein are true and complete to the best of his/her knowledge, information and belief.

_____
[Defendant]

_____
Title

Sworn to and subscribed before me on this the _____ day of _____, 20____.

_____
NOTARY PUBLIC

My Commission Expires:

Respectfully submitted,

MICHAEL K PARSLEY, BPR # 023817
Michael D. Ponce & Associates
Attorneys for Plaintiff
400 Professional Park Drive
Goodlettsville, TN 37072
Telephone: (615) 851-1776

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been served via email, facsimile, hand delivery, and or U.S. First Class Mail, postage prepaid, addressed as follows:

This 6th day of December, 2021.

MICHAEL K PARSLEY, BPR # 023817

PLAINTIFFS' FIRST REQUEST FOR PRODUCTION OF DOCUMENTS TO DEFENDANT

Plaintiff requests that the Defendant produce the following documents pursuant to Rules 26 and 34 of the Tennessee Rules of Civil Procedure.

1. Please produce all documents referred to, identified, or used in answering the Interrogatories set forth above.

RESPONSE:

2. Please produce copies of any and all photographs, diagrams, maps, movies, or videos in your possession that depict the area of the premises in which the Plaintiff Angelica Cruz-Romo claims to have been hit. State when, where, why, and by whom said materials were taken or drawn.

RESPONSE:

3. Please produce all documents and exhibits, photographs, movies, video tapes, charts, recordings, or maps on which you are relying to answer the above Interrogatories and Request for Production of Documents, and/or which you plan to present, even if only as demonstrative evidence, at the trial of this matter.

RESPONSE:

4. Please produce all documents, exhibits, photographs, movies, videotapes, surveillance tapes, maps, recordings, charts, drawings, diagrams, and/or computer-generated renderings in your possession that depict the Plaintiff either before or after the accident that is described in the Complaint.

RESPONSE:

6. If you intend to call an expert witness (witnesses) to testify in this case, please produce the following with respect to each such witness:

(a) A current and complete resume or curriculum vitae for the witness;

(b) A list of all cases the witness has testified in by way of oral deposition or trial testimony, including the name(s) of the attorney(s) who called the witness, during the five (5) year period immediately preceding your response;

(c) Produce a list of all compensation received by the witness, including Internal Revenue Service 1099 Forms for all compensation received by the witness, for providing inspections, consulting, reports, depositions, and trial testimony for all defendants, defense law firms, and/or automobile liability insurance companies during the ten (10) year period immediately preceding your response.

(d) Produce a list of all compensation received by the witness, including Internal Revenue Service 1099 Forms for all compensation received by the witness, for providing inspections, consulting, reports, depositions, and trial testimony for all plaintiffs and/or plaintiffs law firms during the ten (10) year period immediately preceding your response.

(e) All raw facts, information, and/or data, including all notes, tests, photographs, videotapes, audio tapes, results, measurements, computer information, data or computer disks or hard drives, or any other information which in any way was relied upon by the witness in preparation of his/her report, analysis, reconstruction, or in the formulation and preparation of the opinions and conclusions contained therein, or which form the basis of his/her opinion(s) which you intend to offer at the trial of this case;

(f) Copies of any and all literature, journal articles, treatises, technical papers or any other written and/or computer generated material or information of any type relied upon in any way in the preparation of the witness' report,

analysis, reconstruction, or which form the basis of his/her opinion(s) which you intend to offer at the trial of this case.

RESPONSE:

Respectfully submitted,

MICHAEL K PARSLEY, BPR # 023817
Michael D. Ponce & Associates
Attorneys for Plaintiff
400 Professional Park Drive
Goodlettsville, TN 37072
Telephone: (615) 851-1776

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This 6th day of December 2021.

MICHAEL K PARSLEY, BPR # 023817

DEC 13 2021